Prior Authorization Request

Chart Notes Required

Please fax this request to: 503-574-6464 or 800-989-7479
Please call our PA department if you have any questions at: 503-574-6400 or 800-638-0449

Member Information	
Last Name:	First Name:
ID #:	DOB:
Address:	

Provider Information	
Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Servicing Provider:	TIN#:
Address:	NPI#:
Servicing Facility:	TIN#:
Address:	NPI#:

Request Information	
ICD-10 Code(s):	
CPT Code(s):	
Requested Services: ☐ Office Visits, # of visits: ___________________ ☐ Surgery ☐ Diagnostic ☐ Facility Auth Only	Type of Service: ☐ Inpatient ☐ Outpatient Surgery ☐ Office Surgery ☐ Outpatient Diagnostics ☐ ASC
DOS:	**Date Span Requested:**
Comments:	

REQUIRED Contact Information:	
Name:	Phone #:
Fax #:	Total # of pages faxed, including cover page:
☐ **In-Network Benefits being requested**	☐ **PLEASE EXPEDITE!** The provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy (CMS definition)

IMPORTANT NOTICE: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message. May 12, 2016